# Lakeview/Crossroads Family Medicine

811 North 900 West • Orem, UT 84057• Phone (801)434-7600 • Fax (801)434-7604
41 E 1140 N, Suite C • Saratoga Springs, UT 84045•Phone (801)766-2121 • Fax (801)768-2612

## Authorization to Receive, Transmit, Use and Disclose Protected Health Information

Kenneth Crump, MD • Winston Petersen, PA-C • Janice Robinson, NP-C • Lisa Hall, NP-C • Trenaisa Nay, NP-C

| Authorization to release the health information of: | | Type of Records Requested: | | | | |
|---|---|---|---|---|---|---|
| Full Name of Patient | Date of Birth | All Records | Consult Notes | Lab Results | Vaccine Records | Other |
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☐ **Information to be released from this office to:**

Organization Name _____ Phone (____) _____ Fax (____) _____.

Address_____ City_____ State _____ Zip_____.

☐ **Information to be received from:**

Organization Name _____ Phone (____) _____ Fax (____) _____.

Address _____ City _____ State_____ Zip_____.

**I specifically prohibit the release of the following information by initialing below:**

_____ AIDS/ HIV _____ Substance/Alcohol Abuse _____ Mental/Behavioral Health _____ Genetic Information

**This authorization will remain in effect:**

☐ Until the following date _____ -or- until the following event occurs:_____.

***Unless otherwise noted, this authorization will remain in effect 180 days from the date signed.**

**I understand that:**

- Once "this facility" discloses my health information upon my request, it cannot guarantee that recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.
- There is a $35.00 research and retrieval fee charged to third party requestors.
- I may make a request in writing at any time to Lakeview/Crossroads Family Medicine to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR §164.524.
- My records are protected and cannot be disclosed without my written permission.

**To be used if facility requests this authorization:**

- I may refuse to sign or may revoke this authorization at any time and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility's" treatment of me, enrollment in the health plan, or eligibility for benefits.
- I may make a request in writing at any time to Lakeview/Crossroads Family Medicine to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR §164.524.

**Signature of Patient or Legal Representative** _____ **Date**_____.

**Relationship to Patient** _____ **Witness** _____.